Montana Medicaid Claim Jumper

Covered Service Changes

Effective July 1, 2003, Montana Medicaid will implement several changes in coverage of physician-related services. These changes include services that will no longer be covered/reimbursable and services that now need to be prior authorized.

The services that will no longer be covered effective for July 1, 2003 dates of service include dermabrasion, rhytidectomy, liposuction, correction of inverted nipples, plastic surgery on penis to correct angulation, hysterosalpingography, salpingostomy, radial keratotomy, kera-tomileusis, insertion penile prosthesis, construction of vagina, nocturnal penile tumescence and/or rigidity test, and otoplasty.

The services that newly require Prior Authorization effective for July 1, 2003 dates of service include blepharoplasty, botox treatment, excising excessive skin, maxillofacial/cranial, rhinoplasty and septorhinoplasty, temporomandibular joint surgery (TMJ), and positron emission topography (PET) scans.

Please review the June 1, 2003 Provider Notice for specific details of these services and how to initiate prior authorization.

Publications Reminder

It is the providers' responsibility to be familiar with the Medicaid manuals, fee schedules, and notices for their provider type, as well as other information published in the *Claim Jumper* and on the website.

Business Associate Agreements

Many questions have arisen concerning Business Associate Agreements under the Privacy Rule of the Health Insurance Portability and Accountability Act ("HIPAA").

A Business Associate ("BA") is "a person or organization that performs a function on behalf of a Covered Entity that requires the use or disclosure of Protected Health Information ("PHI") and relates to the health care component activities of the Covered Entity. Those functions include claims processing, utilization review, quality assurance, billing, benefits management, legal, actuarial, accounting, consulting, data aggregation, management, administration, accreditation or financial services."

A simple way to determine if the contractor/entity requires a BA Agreement is to answer the following questions:

1. Is the contractor/entity someone other than your employee;
2. Is the contractor/entity performing a function on your behalf;
3. To perform the function, do you give the contractor/entity Individual Identifiable Healthcare Information ("IIHI")? IIHI is information that you create or receive that is collected from an individual and either identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual.

If the response to all three questions is "yes," the contractor/entity would be considered a BA. If the response to question 3 is "no," but the contractor/entity performs one or more functions mentioned in the BA definition, careful review should be given to determine whether the sharing of IIHI is necessary to carry out the contract.
HIPAA allows for information necessary to provide treatment, payment for services and health care operations to be given, without client/patient authorization, so in most cases, there is no need for a BA Agreement between Covered Entities. The Privacy Rule also permits the disclosure of PHI directly to a BA acting on behalf of another Covered Entity.

The Covered Entity is not required to monitor the privacy practices of the BA and is not liable for privacy breaches of the BA. However, language should be written into the contract or agreement with the BA that outlines the HIPAA Privacy Rule and holds the BA responsible for the PHI provided to them by the Covered Entity. If the Covered Entity becomes aware of

any material breach of their agreement, they must take steps to correct or end the violation. If the Covered Entity is unsuccessful in their attempt, they must either terminate the contract or if not feasible, they should report the problem to the Secretary of Health and Human Services.

The United States Department of Health and Human Services website has a site for Frequently Asked Questions pertaining to all aspects of HIPAA. You can access the website via the following address: http://www.hhs.gov/ocr/ then click on View Health Information Privacy Frequently Asked Questions (FAQs). The site is frequently updated with additional questions and can be of significant help.

Hysterectomy Update

Effective July 1, 2003, providers must obtain the client's signature 30 days before a hysterectomy procedure. See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations. See also the *Physician Related Services* manual replacement pages on hysterectomies and sterilizations.

Also, for clarification, hysterectomies performed during a period of retroactive eligibility can be reimbursed if the provider who performed the hysterectomy, certifies in writing that the client was informed prior to the hysterectomy that the procedure would render them permanently sterile or the client was sterile prior to the hysterectomy.

Proton Pump Inhibitor Cost Comparisons

This comparison is to help providers make some sense of relative cost factors for medications provided to Montana Medicaid patients. It is only intended to help providers make prescribing decisions and not market one company's product over another.

The following prices are based on Average Wholesale Price and the rebate manufacturers give back to the Medicaid program.

Aciphex 20mg	$2.65 each
Nexium 20mg	$3.73 each
Nexium 40mg	$3.73 each
Omeprazole 20mg	$3.70 each
Prilosec 20mg	$4.03 each
Prilosec 40mg	$5.88 each
Prevacid 15mg	$3.12 each
Prevacid 30mg	$3.12 each
Protonix 20mg	$2.60 each
Protonix 40mg	$2.60 each

Outpatient Hospital Q & A

Q. I've heard that there are some upcoming changes for PASSPORT clients in the emergency room. What are the changes?

A. With dates of service August 1, 2003, Medicaid will not pay emergency room claims for PASSPORT clients for non-emergent services, even if the PASSPORT PCP has given a referral. Claims with a diagnosis on the pre-approved emergency list will be payed at the appropriate APC level (along with any lab, imaging and diagnostic services that are not bundled) for prospective payment hospitals and will pay hospital specific outpatient cost-to-charge ratio for CAHs and Exempts. If the diagnosis is not on the pre-approved list the claim will be paid a screening and evaluation fee that is subject to cost share. If the diagnosis is not on the list, but the provider conducting the screening evaluation believes it is an emergency, the claim and documentation supporting the emergent nature of the condition can be sent in and the claim can be reimbursed as an emergency.

Q. Do I have to have a line-item date of service on inpatient claims?

A. No. This HIPAA requirement is strictly for outpatient claims only.

Q. My facility is a critical access hospital. What changes will I see August 1st?

A. Critical access and exempt (isolated) hospitals will both be reimbursed an interim fee based on their cost to charge ratio for all allowed inpatient and outpatient services. They will be cost settled. PASSPORT changes for emergency visits also apply.

Q. I spoke with ACS and verified that a provider is not able to bill Medicaid for a service when the DX code is V65.2 Person Feigning Illness. Can we bill the patient if a Medicaid denial is received for this DX code?

A. Unless the patient is told prior to a service or directly after triage that they are responsible for payment you may not bill the patient. As soon as your staff determines that the patient is feigning an illness, the patient should be told that they are responsible for payment and all usual and customary collection methods may be used. We suggest that you inform the patient in writing and if possible have them sign a form that states they acknowledge responsibility for payment for the specific date of service and the particular service the patient is responsible for. If that is not possible make sure your records clearly document the patient was informed and by whom.

Provider Satisfaction Survey

We would appreciate your feedback on our performance. The information you provide is a valued tool to improve our services and provide quality customer service. Please complete the survey, fold it in half and return it to ACS. Thank you for helping us to improve our service.

Provider Medicaid Number_____ Provider Name_____

Provider Type_____ Provider Specialty_____
(i.e., physician, hospital, etc.)

Contact Name_____ Phone Number_____

Survey Questionnaire

How does ACS compare to other payers for: 5--Much Better 4--Somewhat Better 3-Same 2--Somewhat Worse 1--Much Worse						
1. Claim processing speed	5	4	3	2	1
Please explain your rating:						
2. Problem claim resolution	5	4	3	2	1
Please explain your rating:						
3. Customer service	5	4	3	2	1
Please explain your rating:						
4. Provider training	5	4	3	2	1
Please explain your rating:						
5. Provider Information (i.e., Claim Jumper, Website, Manuals, Notices)	5	4	3	2	1
Please explain your rating:						

Rate ACS Provider Relations 5--Excellent 4--Good 3--Fair 2--Poor 1--Unacceptable					
1. How professional and courteous were ACS employees during your calls?	5	4	3	2	1
2. How knowledgeable were ACS employees regarding Medicaid information for your provider type?	5	4	3	2	1
3. How completely were your questions answered?	5	4	3	2	1
4. Were commitments made to you during the call completed timely?	5	4	3	2	1
5. How would you rate the service your received overall?	5	4	3	2	1
6. If your office has had a field visit, rate the quality of the field visit.	5	4	3	2	1

Would it be beneficial to have a group of ACS call center staff dedicated to your specific claim type? (i.e., CMS-1500, UB-92, Dental, Nursing Facility, Pharmacy) ☐ Yes ☐ No

Additional Comments Please:

Place Stamp Here

Montana Medicaid
P.O. Box 4936
Helena, MT 59604

Recent Publications

The following are brief summaries of publications regarding program policy changes since December 1, 2002. For details and further instructions, download the complete notice from the Provider Information website (http://www.mtmedicaid.org). Select *Notices and Replacement Pages*, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

Notices

06/01/03 Physicians, Mid Levels, ASCs, IHS, IDTF, Lab & X-Ray, Podiatrist, Psychiatrist *New*

- PA Criteria Changes
- Services no longer covered

05/12//03 RBRVS Billers *New*

- Provider Rate and Payment Reductions
- Disposable Incontinence Products

05/05/03 School Based Services Providers *New*

- CSCT Program Reinstated

05/01/03 Hospitals, Physicians, Mid Levels, Lab & X-Ray, Podiatrists, IDTFs, Psychiatrists *Updated*

- The effective date of this notice has been changed to July 1, 2003.
- Updated with Lab Panel Billing Information

04/30/03 Physicians, Mid Levels, Hospitals, Ambulatory Surgical Centers

- Gastric Bypass and Circumcision

04/14/03 School Based Services Providers

- New Services

04/01/03 DRG Hospitals

- Rehabilitation Billing and Payment Changes

03/03/03 DME Providers

- Coding and Reimbursement Revisions

03/03/03 DME Providers

- 2003 Deleted HCPCS Codes

03/01/03 Pharmacy Providers

- Prior authorization and refill changes

03/01/03 CMS-1500 Billers

- New HCPCS/CPD Codes
- Deleted HCPCS/CPT Codes
- New J Codes

03/01/03 Nutrition Providers

- Nutrition Services Require PASSPORT Approval

02/28/03 DME Providers

- New Modifier - BO

02/06/03 Dental Notice

- New CDT-4 Dental Codes effective 02/01/03.

02/04/03 Outpatient Hospitals, FQHC, RHC, IHS

- UB-92 claims submitted on or after April 1, 2003, will require all line items to have a valid date of services (UB field 45).
- List of revenue codes that require a separate line for each date of service

Manuals

04/02/03 Optometric and Eyeglass Services Manual

- This new manual does not include the temporary program changes effective February 1, 2003 through June 30, 2003.

01/06/03 Ambulance Services Manual

- This new manual contains the latest program changes and updates.

Manual Replacement Pages

01/02/03 Pharmacy Manual Replacement Pages

- Replacement pages for the Prior Authorization chapter of the Pharmacy manual

01/02/03 Physician Manual Replacement Pages

- Prior authorization changes

Visit: mtmedicaid.org

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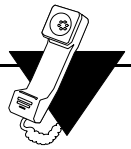

Key Contacts

Provider Information Website:
http://www.mtmedicaid.org

Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax

TPL (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state

Direct Deposit Arrangements (406) 444-5283

Verify Client Eligibility:
FAXBACK (800) 714-0075
Automated Voice Response (800) 714-0060

Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944

PASSPORT (800) 480-6823

Prior Authorization:
DMEOPS(406) 444-0190
Mountain-Pacific Quality Healthcare Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7951

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability (TPL)
P.O. Box 5838
Helena, MT 59604